

VIROLOGY LABORATORY—Room 713  
STATE LABORATORY INSTITUTE  
305 South St.  
Boston, MA 02130

**SPECIMEN COLLECTION FOR DIAGNOSIS OF RUBELLA**

**ANTIBODY DETECTION**

Submission of specimens to the Virology Laboratory at the State Laboratory Institute must be coordinated through an immunization epidemiologist at 617-983-6800. Technical questions about specimen collection can be addressed to the Virology Laboratory at 617-983-6383 or 983-6396.

<b>Specimen type:</b>	<b>Serum for rubella IgM antibody (serology for acute infection).</b>
Collection procedure:	Venipuncture. Serum-separator tubes (SST) preferred, red-top tubes acceptable.
Optimum collection time:	<u>CRS</u> : At birth or as soon as possible after birth. <u>Exposed pregnant women</u> : Immediately. <u>Rubella (non-CRS)</u> : $\geq 3$ days after rash onset. <u>Note</u> : In all of the above cases, follow-up specimens for additional testing may be required.
Transportation container:	Serum in polystyrene (plastic) tube, or blood in SST, preferably centrifuged.
Volume:	2 ml. serum; $\geq 0.5$ ml. acceptable for young children.
Transport:	Cold, use ice packs. <b>DO NOT FREEZE.</b>

**IMPORTANT!:** To avoid loss or misdirection of the specimen within the 8-story State Laboratory building, PLEASE FILL OUT THE ATTACHED REQUISITION FORM AS COMPLETELY AS POSSIBLE AND ENCLOSE WITH THE SPECIMEN.

**Massachusetts Department of Public Health  
State Laboratory Institute  
Specimen Request**

*(This form must be included with the specimen)*

Epidemiologist: \_\_\_\_\_

Requested from: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Contact name: \_\_\_\_\_

*Please complete the following information.*

Test(s) requested: \_\_\_\_\_

**Send Report To:**

**Specimen Information:**

Physician: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Facility: \_\_\_\_\_

Patient Address \_\_\_\_\_

Street: \_\_\_\_\_

\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

Telephone: \_\_\_\_\_

Onset of Symptoms: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date(s) of Specimen Collection: \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Brief summary of symptoms/clinical history/hospitalization:

Recent travel history? (If yes, please explain):

Relevant Vaccine History: \_\_\_\_\_  
Type of vaccine

\_\_\_\_/\_\_\_\_/\_\_\_\_  
date of 1<sup>st</sup> dose

\_\_\_\_/\_\_\_\_/\_\_\_\_  
date of 2<sup>nd</sup> dose

\_\_\_\_/\_\_\_\_/\_\_\_\_  
date of 3<sup>rd</sup> dose

**Specimen Type:** \_\_\_\_\_ **Shipping Requirements:** [ ] Room Temp. [ ] Refrigerate [ ] Frozen

**Send Completed Form and Specimen to:**

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**State Laboratory Institute**

\_\_\_\_\_  
**(Specific Laboratory Contact)**

**305 South Street  
Boston, MA 02130  
(617) 983-6200**